

UNITED STATES DEPARTMENT OF THE INTERIOR
 BUREAU OF SAFETY AND ENVIRONMENTAL ENFORCEMENT
 GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED

DATE: **23-JAN-2020** TIME: **1200** HOURS

2. OPERATOR: **Walter Oil & Gas Corporation**

REPRESENTATIVE:

TELEPHONE:

CONTRACTOR: **ISLAND OPERATORS CO. INC.**

REPRESENTATIVE:

TELEPHONE:

- STRUCTURAL DAMAGE
- CRANE
- OTHER LIFTING
- DAMAGED/DISABLED SAFETY SYS.
- INCIDENT >\$25K **Compr.Eng.Repairs**
- H2S/15MIN./20PPM
- REQUIRED MUSTER
- SHUTDOWN FROM GAS RELEASE
- OTHER

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

8. OPERATION:

4. LEASE: **G31418**

AREA: **ST** LATITUDE:

BLOCK: **311** LONGITUDE:

- PRODUCTION
- DRILLING
- WORKOVER
- COMPLETION
- HELICOPTER
- MOTOR VESSEL
- PIPELINE SEGMENT NO.
- OTHER

5. PLATFORM: **A**

RIG NAME:

6. ACTIVITY:

- EXPLORATION(POE)
- DEVELOPMENT/PRODUCTION (DOCD/POD)

9. CAUSE:

7. TYPE:

INJURIES:

HISTORIC INJURY

OPERATOR CONTRACTOR

REQUIRED EVACUATION

0 2

LTA (1-3 days)

LTA (>3 days)

RW/JT (1-3 days)

RW/JT (>3 days)

FATALITY

Other Injury

0 2

Full Duty Release

POLLUTION

FIRE

EXPLOSION

LWC

HISTORIC BLOWOUT

UNDERGROUND

SURFACE

DEVERTER

SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION

HISTORIC

>\$25K

<=\$25K

- EQUIPMENT FAILURE
- HUMAN ERROR
- EXTERNAL DAMAGE
- SLIP/TRIP/FALL
- WEATHER RELATED
- LEAK
- UPSET H2O TREATING
- OVERBOARD DRILLING FLUID
- OTHER _____

10. WATER DEPTH: **391** FT.

11. DISTANCE FROM SHORE: **64** MI.

12. WIND DIRECTION:
SPEED: M.P.H.

13. CURRENT DIRECTION:
SPEED: M.P.H.

14. SEA STATE: FT.

15. PICTURES TAKEN:

16. STATEMENT TAKEN:

17. INVESTIGATION FINDINGS:

At approximately 1200 hours on January 23, 2020, an incident occurred at South Timbalier Block 311 Platform A, Lease Number OCS-G31418. The Operator on record is Walter Oil & Gas Corporation.

Offshore platform personnel were testing levels on an in-service LP Gas Compressor. After completing a test of the 3rd stage scrubber LSH (Level Safety High), the operator inadvertently opened a ball valve connected to the bottom of the LSH bridle with his foot/shin while exiting the area. This resulted in the release of approximately 1100 psi (pounds per square inch) through a 3/8" stainless steel tubing drain line approximately 7 feet in length. The pressure release caused a whipping action in the drain tubing striking the operator on the side of the face/hardhat. Hydrocarbons from the 3rd stage suction scrubber vented toward the in-service LP gas compressor engine and ignited. Platform personnel activated the manual ESD (Emergency Shutdown) station, signaled the fire alarm, and all other personnel mustered. An attempt was made to use a nearby 125 lb. wheeled unit but it failed to discharge. Fire water was used to extinguish the fire allowing access to close the ball valve.

Personnel reported first aid injuries (scraps, bumps, and skin redness). The fire caused damage to the compressor engine electrical components/wiring and the 3rd stage discharge PSV (Pressure Safety Valve).

BSEE Inspectors arrived on location to investigate the incident on January 24, 2019, after being notified of the fire and injuries requiring first aid. Inspectors interviewed personnel and gathered witness statements. Pictures were taken of the LP Gas Compressor and 125 lb. Wheeled unit.

1. It is possible the self-locking mechanism on the ball valve handle was stuck in the "up" position at the time the incident occurred. The valve handle and self-locking mechanism did not appear to be bent or damaged as a result of the inadvertent opening. Inspectors did not find evidence of supports and/or bracing used to secure the stainless-steel tubing prior to the incident.

2. The LP Gas Compressor was in-service and at operating temperatures when the incident occurred. The end of the stainless-steel tubing was pointed in the direction of the engine and location of damages to parts on the engine proves it as the probable ignition source.

3. The wheeled unit was sent to a 3rd party firefighting inspection company by the Lessee and determined it failed to discharge due to a chemical packed siphon tube caused by exposure to vibration. The wheeled unit that failed to perform was stationed near the LP Gas Compressor. Previous annual firefighting inspection reports did not state if the siphon tube was checked as per manufacturers service instructions.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

- Drain line tubing was not secured.
- Tubing end was not capped/plugged off.
- The Ball valve handle locking mechanism failed to prevent inadvertent opening.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

Annual inspection of the wheeled unit siphon tube was not conducted as per manufactures servicing instructions.

20. LIST THE ADDITIONAL INFORMATION:

None

21. PROPERTY DAMAGED:

NATURE OF DAMAGE:

Gas Compressor devices

- 3rd stge discharge PSV
- engine wiring replaced
- TSE's replaced

- burnt PSV

- melted wiring

- melted fusible material in TSE

ESTIMATED AMOUNT (TOTAL):

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

None

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None

25. DATE OF ONSITE INVESTIGATION:

23-JAN-2020

28. ACCIDENT CLASSIFICATION:

26. INVESTIGATION TEAM MEMBERS:

Andrew Gros / Greg Liner / Keith Barrios /

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

27. OPERATOR REPORT ON FILE:

30. DISTRICT SUPERVISOR: **Amy**

Pellegrin

APPROVED

DATE:

25-AUG-2020